FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042176

Facility Name: Renaissance at Hillside

Address: 4600 North Frontage Road (Number) Hillside (City) 60162 (Zip Code)

County: Cook

Telephone Number: (708) 544-9933 **Fax #** (708) 544-9966

HFS ID Number: 363980624001

Date of Initial License for Current Owners: 06/30/97

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Kimberley A. Waite, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	168	Skilled (SNF)	168	61,320	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,320	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	39,523	3,682	11,220	54,425	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,523	3,682	11,220	54,425	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.76%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/30/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/30/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 168 and days of care provided 9,570

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/313/05

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	297,065	57,033	20,398	374,496		374,496		374,496			1
2	Food Purchase		275,202		275,202		275,202	(696)	274,506			2
3	Housekeeping	261,612	34,754		296,366		296,366	(6,323)	290,043			3
4	Laundry		22,773		22,773		22,773		22,773			4
5	Heat and Other Utilities			201,412	201,412		201,412	(10,543)	190,869			5
6	Maintenance	42,303	34,705	85,177	162,185		162,185	(12,554)	149,631			6
7	Other (specify):*											7
8	TOTAL General Services	600,980	424,467	306,987	1,332,434		1,332,434	(30,116)	1,302,318			8
	B. Health Care and Programs											
9	Medical Director			20,900	20,900		20,900		20,900			9
10	Nursing and Medical Records	2,467,732	182,706	270,705	2,921,143		2,921,143	(22)	2,921,121			10
10a	Therapy	205,321		1,456	206,777		206,777		206,777			10a
11	Activities	128,811	25,710	2,551	157,072		157,072	(18,163)	138,909			11
12	Social Services	135,744		3,336	139,080		139,080		139,080			12
13	CNA Training											13
14	Program Transportation			2,099	2,099		2,099		2,099			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,937,608	208,416	301,047	3,447,071		3,447,071	(18,185)	3,428,886			16
	C. General Administration											
17	Administrative	171,941		519,443	691,384		691,384	(469,179)	222,205			17
18	Directors Fees											18
19	Professional Services			93,447	93,447		93,447	(12,923)	80,524			19
20	Dues, Fees, Subscriptions & Promotions			110,123	110,123		110,123	(50,854)	59,269			20
21	Clerical & General Office Expenses	198,407	40,625	386,699	625,731		625,731	(280,739)	344,992			21
22	Employee Benefits & Payroll Taxes			719,776	719,776		719,776	(31,125)	688,651			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,277	8,277		8,277	(133)	8,144			24
25	Other Admin. Staff Transportation			3,064	3,064		3,064	300	3,364			25
26	Insurance-Prop.Liab.Malpractice			208,986	208,986		208,986	4,187	213,173			26
27	Other (specify):*							25,156	25,156			27
28	TOTAL General Administration	370,348	40,625	2,049,815	2,460,788		2,460,788	(815,310)	1,645,478			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,908,936	673,508	2,657,849	7,240,293		7,240,293	(863,611)	6,376,682			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Renaissance at Hillside #0042176 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			124,842	124,842		124,842	4,450	129,292			30
31	Amortization of Pre-Op. & Org.			7,522	7,522		7,522		7,522			31
32	Interest			369,463	369,463		369,463	(15,881)	353,582			32
33	Real Estate Taxes			426,443	426,443		426,443	1,856	428,299			33
34	Rent-Facility & Grounds			1,166,145	1,166,145		1,166,145	370	1,166,515			34
35	Rent-Equipment & Vehicles			8,753	8,753		8,753	2,560	11,313			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,103,168	2,103,168		2,103,168	(6,645)	2,096,523			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,786	458,551	712,880	1,174,217		1,174,217		1,174,217			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			91,980	91,980		91,980		91,980			42
43	Other (specify):*	132,407		4,078	136,485		136,485	(136,485)				43
44	**TOTAL Special Cost Centers**	135,193	458,551	808,938	1,402,682		1,402,682	(136,485)	1,266,197			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,044,129	1,132,059	5,569,955	10,746,143		10,746,143	(1,006,741)	9,739,402			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,377)	30		9
10	Interest and Other Investment Income	(944)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(186)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(5,937)	21		18
19	Entertainment	(734)	21		19
20	Contributions	(21,599)	20		20
21	Owner or Key-Man Insurance	(29,125)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(205,017)	21		24
25	Fund Raising, Advertising and Promotional	(28,616)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(211)	20		28
29	Other-Attach Schedule	(417,415)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (712,161)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(294,580)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (294,580)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,006,741)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Renaissance at Hillside

ID# 0042176

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Charges	$ (11,340)	21	1
2	Cable	(12,753)	5	2
3	Patient Clothing	(1,374)	11	3
4	Patient Needs	(16,789)	11	4
5	Non-Allowable Legal Fees	(16,283)	19	5
6	Marketing Consultant	(4,078)	43	6
7	Misc Income - Meals	(141)	2	7
8	Misc Income - Gloves	(22)	10	8
9	Misc Income - Rebates	(369)	2	9
10	Misc Income - Office	(592)	21	10
11	COPE Dues	(2,000)	20	11
12	2005 Seminar Expense (from prior year)	29	24	12
13	2006 Seminar Expense	(760)	24	13
14	Marketing Salary	(84,359)	43	14
15	Non-Allowable Salaries	(36,100)	21	15
16	Non-Allowable Cell Phone Usage	(2,206)	21	16
17	Non-Allowable Holiday Expense	(2,000)	22	17
18	Non-Allowable Expense	(120,000)	21	18
19	Non-Allowable Salaries	(48,048)	43	19
20	Misc Income - Housekeeping	(6,323)	03	20
21	Misc Income - Plant	(15,611)	06	21
22	Misc Income - Office	(19,447)	21	22
23	Misc Income - Interest	(15,872)	32	23
24	Non-Allowable Cell Phone Usage	(841)	27	24
25	Non-Allowable Holiday Expense	(136)	27	25
26				26
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99				99
100				100
101	**Total**	(417,415)		101

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Renaissance at Hillside # 0042176 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
1	Dietary													1
2	Food Purchase	(696)											(696)	2
3	Housekeeping	(6,323)											(6,323)	3
4	Laundry													4
5	Heat and Other Utilities	(12,753)				2,210							(10,543)	5
6	Maintenance	(15,611)				3,057							(12,554)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(35,383)				5,267							(30,116)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(22)											(22)	10
10a	Therapy													10a
11	Activities	(18,163)											(18,163)	11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(18,185)											(18,185)	16
	C. General Administration													
17	Administrative			(3,477)	(112,554)	(353,148)							(469,179)	17
18	Directors Fees													18
19	Professional Services	(16,283)		403	455	2,502							(12,923)	19
20	Fees, Subscriptions & Promotions	(52,426)		190		1,382							(50,854)	20
21	Clerical & General Office Expenses	(401,373)		1,308	874	118,452							(280,739)	21
22	Employee Benefits & Payroll Taxes	(31,125)											(31,125)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(731)		128		470							(133)	24
25	Other Admin. Staff Transportation					300							300	25
26	Insurance-Prop.Liab.Malpractice					4,187							4,187	26
27	Other (specify):*	(977)		2,858	823	22,452							25,156	27
28	**TOTAL General Administration**	(502,915)		1,410	(110,402)	(203,403)							(815,310)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(556,483)		1,410	(110,402)	(198,136)							(863,611)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Renaissance at Hillside** **#** **0042176** **Report Period Beginning:** **01/01/05** **Ending:** **12/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(2,377)				6,827							4,450	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(16,816)				935							(15,881)	32
33	Real Estate Taxes					1,856							1,856	33
34	Rent-Facility & Grounds					370							370	34
35	Rent-Equipment & Vehicles					2,560							2,560	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(19,193)				12,548							(6,645)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(136,485)											(136,485)	43
44	**TOTAL Special Cost Centers**	(136,485)											(136,485)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(712,161)		1,410	(110,402)	(185,588)							(1,006,741)	45

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	There is no longer any common ownership between		$	$	1
2	V				the nursing home and the building company.				2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 14,123	$ 14,123	15
16	V		19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	403	403	16
17	V		20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	190	190	17
18	V		21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	1,308	1,308	18
19	V		24	SEMINARS		CAREPATH HEALTH NETWORK	100.00%	128	128	19
20	V		27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	2,858	2,858	20
21	V									21
22	V									22
23	V									23
24	V		17	MANAGEMENT FEES	17,600	CAREPATH HEALTH NETWORK	100.00%		(17,600)	24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 17,600			$ 19,010	$ * 1,410	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR MANAGEMENT CORP.	100.00%	$ 7,446	$ 7,446	15
16	V	19	PROFESSIONAL FEES		JLR MANAGEMENT CORP.	100.00%	455	455	16
17	V	21	OFFICE		JLR MANAGEMENT CORP.	100.00%	874	874	17
18	V	27	PAYROLL TAXES		JLR MANAGEMENT CORP.	100.00%	823	823	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	120,000	JLR MANAGEMENT CORP.	100.00%		(120,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 120,000			$ 9,598	$ * (110,402)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	NUCARE SERVICES CORP.	100.00%	$ 2,210	$ 2,210	15
16	V	6	REPAIRS AND MAINT.		NUCARE SERVICES CORP.	100.00%	3,057	3,057	16
17	V	17	ADMINISTRATIVE - NON-OWNER		NUCARE SERVICES CORP.	100.00%	16,246	16,246	17
18	V	19	PROFESSIONAL FEES		NUCARE SERVICES CORP.	100.00%	2,502	2,502	18
19	V	20	FEES SUBSCRIPTIONS		NUCARE SERVICES CORP.	100.00%	1,382	1,382	19
20	V	21	CLERICAL & GENERAL		NUCARE SERVICES CORP.	100.00%	118,452	118,452	20
21	V	24	SEMINARS AND EDUCATION		NUCARE SERVICES CORP.	100.00%	470	470	21
22	V	25	ADMIN. STAFF TRAVEL		NUCARE SERVICES CORP.	100.00%	300	300	22
23	V	26	INSURANCE		NUCARE SERVICES CORP.	100.00%	4,187	4,187	23
24	V	27	EMPLOYEE BEN. GEN. ADMIN.		NUCARE SERVICES CORP.	100.00%	20,683	20,683	24
25	V	30	DEPRECIATION		NUCARE SERVICES CORP.	100.00%	6,827	6,827	25
26	V	32	INTEREST EXPENSE		NUCARE SERVICES CORP.	100.00%	935	935	26
27	V	33	REAL ESTATE TAX		NUCARE SERVICES CORP.	100.00%	1,856	1,856	27
28	V	34	BUILDING RENT		NUCARE SERVICES CORP.	100.00%	370	370	28
29	V	35	EQUIPMENT RENTAL		NUCARE SERVICES CORP.	100.00%	2,560	2,560	29
30	V	17	ADMIN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	3,391	3,391	30
31	V	17	ADMIN. - B. CARR		NUCARE SERVICES CORP.	100.00%	9,058	9,058	31
32	V	17	ADMIN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%			32
33	V	27	EMP. BEN. - R. HARTMAN		NUCARE SERVICES CORP.	100.00%	1,153	1,153	33
34	V	27	EMP. BEN. - B. CARR		NUCARE SERVICES CORP.	100.00%	616	616	34
35	V	27	EMP. BEN. - D. HARTMAN		NUCARE SERVICES CORP.	100.00%			35
36	V	17	MANAGEMENT FEES	381,843	NUCARE SERVICES CORP.	100.00%		(381,843)	36
37	V								37
38	V								38
39	Total			$ 381,843			$ 196,255	$ * (185,588)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	Workmans Compensation	$ 60,509	Diamond Insurance	40.00%	$ 60,509	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 60,509			$ 60,509	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Hartman	Owner	Administrative	20.05%	See Attached	1.36	2.72%	Nucare alloc	$ 3,391	17-7	1
2	Jack Rajchenbach	Owner	Administrative	25.00%	See Attached	5.00	7.69%	JLR alloc.	7,445	17-7	2
3	Bernard Hollander	Owner	Administrative	25.00%	See Attached	2.00	3.08%				3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,836		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	305,641	9	$ 253,650	$ 253,650	17,018	$ 14,123	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	305,641	9	7,234		17,018	403	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	305,641	9	3,415		17,018	190	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	305,641	9	23,496		17,018	1,308	4
5	24	SEMINARS	CARE PATH FEES	305,641	9	2,300		17,018	128	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	305,641	9	51,334		17,018	2,858	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 341,429	$ 253,650		$ 19,010	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JLR MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HOURS WORKED	55	10	$ 81,900	$ 81,900	5	$ 7,446	1
2	19	PROFESSIONAL FEES	AVG. HOURS WORKED	55	10	5,000		5	455	2
3	21	OFFICE	AVG. HOURS WORKED	55	10	9,614	9,614	5	874	3
4	27	PAYROLL TAXES	AVG. HOURS WORKED	55	10	9,055		5	823	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 105,569	$ 91,514		$ 9,598	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: NUCARE SERVICES CORP.
Street Address: 7257 N. LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 933-2600
Fax Number: (847) 933-2601

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	AVAIL. CENSUS DAYS	904,250	11	$ 32,587	$	61,320	$ 2,210	1
2	6	REPAIRS AND MAINT.	AVAIL. CENSUS DAYS	904,250	11	45,083		61,320	3,057	2
3	17	ADMINISTRATIVE - NON-OWN	AVAIL. CENSUS DAYS	904,250	11	239,568	232,849	61,320	16,246	3
4	19	PROFESSIONAL FEES	AVAIL. CENSUS DAYS	904,250	11	36,902		61,320	2,502	4
5	20	FEES SUBSCRIPTIONS	AVAIL. CENSUS DAYS	904,250	11	20,379		61,320	1,382	5
6	21	CLERICAL & GENERAL	AVAIL. CENSUS DAYS	904,250	11	1,746,738	1,454,049	61,320	118,452	6
7	24	SEMINARS AND EDUCATION	AVAIL. CENSUS DAYS	904,250	11	6,935		61,320	470	7
8	25	ADMIN. STAFF TRAVEL	AVAIL. CENSUS DAYS	904,250	11	4,428		61,320	300	8
9	26	INSURANCE	AVAIL. CENSUS DAYS	904,250	11	61,742		61,320	4,187	9
10	27	EMPLOYEE BEN. GEN. ADMIN	AVAIL. CENSUS DAYS	904,250	11	304,996		61,320	20,683	10
11	30	DEPRECIATION	AVAIL. CENSUS DAYS	904,250	11	100,669		61,320	6,827	11
12	32	INTEREST EXPENSE	AVAIL. CENSUS DAYS	904,250	11	13,784		61,320	935	12
13	33	REAL ESTATE TAX	AVAIL. CENSUS DAYS	904,250	11	27,371		61,320	1,856	13
14	34	BUILDING RENT	AVAIL. CENSUS DAYS	904,250	11	5,450		61,320	370	14
15	35	EQUIPMENT RENTAL	AVAIL. CENSUS DAYS	904,250	11	37,756		61,320	2,560	15
16	17	ADMIN. - R. HARTMAN	AVG. HOURS WORKED	20	11	50,000	50,000	1	3,391	16
17	17	ADMIN. - B. CARR	AVG. HOURS WORKED	50	11	133,580	133,580	3	9,058	17
18	17	ADMIN. - D. HARTMAN	AVG. HOURS WORKED	40	2	4,069	4,069			18
19	27	EMP. BEN. - R. HARTMAN	AVG. HOURS WORKED	20	11	17,006		1	1,153	19
20	27	EMP. BEN. - B. CARR	AVG. HOURS WORKED	50	11	9,079		3	616	20
21	27	EMP. BEN. - D. HARTMAN	AVG. HOURS WORKED	40	2	4,925				21
22										22
23										23
24										24
25	TOTALS					$ 2,903,047	$ 1,874,548		$ 196,255	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Diamond Insurance
Street Address: 40 Skokie Blvd. Suite 105
City / State / Zip Code: Northbrrook, IL 60062
Phone Number: (847) 599-1002
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	Workmans Compensation	Direct Allocation			$	$		$ 60,509	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 60,509	25

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Shareholder Loan		X				$	$ 3,949,576			$ 308,590	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6												6
7	Sun Joint Venture		X								40,582	7
8	See Supplemental Schedule										21,226	8
9	TOTAL Facility Related						$	$ 3,949,576			$ 370,398	9
	B. Non-Facility Related*											
10	Interest Income										(944)	10
11	Allocate to Asst Living										(15,872)	11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (16,816)	14
15	TOTALS (line 9+line14)						$	$ 3,949,576			$ 353,582	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Hillside Limited Partnership		X				$	$			$ 20,291	8
9	Allocated from Nucare		X								935	9
10												10
11												11
12												12
13												13
14	TOTAL Working Capital										21,226	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Renaissance at Hillside # 0042176 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.	***Important*** **,** please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 327,446	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 332,554	2
3. Under or (over) accrual (line 2 minus line 1).		$ 5,108	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 423,191	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 428,299	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	382,956	8
	2001	406,970	9
	2002	462,606	10
	2003	328,428	11
	2004	330,698	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Allocated from 7257 N. Lincoln $1856

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance at Hillside COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042176

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-17-101-014-0000	Long Term Care Property	$ 516,716.39	$ 330,698.00
2.	10-27-319-028-0000	Home Office Allocation	$ 91,772.00	$ 1,559.57
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 608,488.39	$ 332,257.57

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your real estate tax bills for calendar 2004.

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2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Renaissance at Hillside COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042176

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2005.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 50,306 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Hillside Assisted Living Center, Ltd - Assited Living Center - The Assisted Living was closed in May 2005. They are in the process of converting the area to nursing facility beds.
Hillside Monterssori School - Child Day Care
27,945 square feet combined for Assisted Living and Day Care

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 37,608 2. Number of Years Over Which it is Being Amortized: 5

3. Current Period Amortization: 7,522 4. Dates Incurred: 2002

Nature of Costs: Loan Fees
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2	Allocated - 7257 N. Lincoln			5,282	2
3	TOTALS			$ 5,282	3

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1997	12,990		20	650	650	5,431	9
10	Various			1998	40,341		20	2,017	2,017	15,179	10
11	Various			1999	52,100		20	2,606	2,606	17,182	11
12	Various			2000	30,099		20	2,181	2,181	25,277	12
13	Various			2001	49,889		20	2,496	2,496	11,611	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)								67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		70,690	3,169		2,383	(786)	4,551	68
69	Financial Statement Depreciation			76,473			(76,473)		69
70	TOTAL (lines 4 thru 69)		$ 256,109	$ 79,642		$ 12,333	$ (67,309)	$ 79,231	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 256,109	$ 79,642		$ 12,333	$ (67,309)	$ 79,231	1
2	Circuit Breaker Repairs	2002	1,675		20	168	168	642	2
3	6 Motors/Fan Caps	2002	2,435		20	244	244	933	3
4	Air Cooled Chiller/Elec.	2002	88,400		20	8,840	8,840	32,413	4
5	Landscaping	2002	2,097		20	140	140	501	5
6	Fire Sprinkler Work	2002	1,055		20	151	151	527	6
7	Furnish/Install Lamps	2002	30,828		20	6,166	6,166	21,580	7
8	Carpet	2002	1,158		20	165	165	510	8
9	Electricwork	2002	(4,620)		20	(462)	(462)	(1,848)	9
10	Electricwork	2002	(897)		20	(90)	(90)	(359)	10
11	Decorating & Painting	2002	1,044		20	52	52	209	11
12	Awnings	2003	4,905		20	491	491	1,145	12
13	Door Access System	2003	6,000		20	600	600	1,650	13
14	Carpeting	2004	3,648		20	521	521	1,042	14
15	Drywall And Hardware	2004	1,400		20	140	140	280	15
16	Wanderguard System	2004	10,855		20	1,551	1,551	2,455	16
17	Water Heater Repairs	2004	775		20	71	71	71	17
18	Radiator Repairs	2004	1,583		20	145	145	145	18
19	Elevator Repairs	2004	1,153		20	82	82	82	19
20	Therapy Room Mural	2004	1,400		20	82	82	82	20
21	Generator Repairs	2004	940		20	51	51	51	21
22	Doors	2005	353		20	32	32	32	22
23	Fence	2005	1,580		20	145	145	145	23
24	Camera/Vcr Security System	2005	728		20	87	87	87	24
25	Wallguard	2005	643		20	536	536	536	25
26	Wallguard	2005	534		20	401	401	401	26
27	Hvac Equipment	2005	514		20	49	49	49	27
28	Fire Alarm Equipment	2005	1,550		20	148	148	148	28
29	Patio Doors	2005	2,692		20	157	157	157	29
30	Fire Sprinkler	2005	1,090		20	117	117	117	30
31	Granite Top And Wood Shelf	2005	3,220		20	161	161	161	31
32	Handicap Access Ramp	2005	450		20	19	19	19	32
33	Parking Lot	2005	5,285		20	220	220	220	33
34	TOTAL (lines 1 thru 33)		$ 430,582	$ 79,642		$ 33,513	$ (46,129)	$ 143,414	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 430,582	$ 79,642		$ 33,513	$ (46,129)	$ 143,414	1
2	Carpeting	2005	2,486		20	148	148	148	2
3	Digital Signaling Device	2005	1,057		20	44	44	44	3
4	2 Ton Condenser/Thermostat Misc	2005	866		20	36	36	36	4
5	Floor Tile	2005	18,700		20	416	416	416	5
6	Coffee Table And Wall Molding	2005	3,550		20	118	118	118	6
7	Nurses Station	2005	10,000		20	333	333	333	7
8	Wallcovering	2005	228		20	114	114	114	8
9	Wallcovering	2005	1,512		20	504	504	504	9
10	Wallcovering	2005	4,819		20	2,008	2,008	2,008	10
11	Wallcovering	2005	4,890		20	1,630	1,630	1,630	11
12	Chandelier	2005	1,279		20	43	43	43	12
13	Wallcovering	2005	4,597		20	1,532	1,532	1,532	13
14	Sconces	2005	3,335		20	111	111	111	14
15	Wallcovering	2005	6,736		20	2,245	2,245	2,245	15
16	Overhead Light Fixture	2005	2,734		20	68	68	68	16
17	Wallcovering	2005	1,180		20	295	295	295	17
18	Tile Floor	2005	19,158		20	319	319	319	18
19	Tile Floor	2005	2,658		20	59	59	59	19
20	Tile Floor	2005	1,240		20	28	28	28	20
21	Tile Floor	2005	1,128		20	19	19	19	21
22	Flooring	2005	37,984		20	422	422	422	22
23	Curtains, Window Treatments	2005	14,141		20	589	589	589	23
24	Magnetic Locks	2005	539		20	40	40	40	24
25	Carpeting	2005	562		20	7	7	7	25
26	Platform Mounted Parallel Bar	2005	1,325		20	22	22	22	26
27	Wallcovering	2005	1,334		20	222	222	222	27
28	Tile Floor	2005	2,239		20	12	12	12	28
29	Tile Floor	2005	852		20	5	5	5	29
30	Tile Floor	2005	1,313		20	7	7	7	30
31	New Floor	2005	9,682		20	54	54	54	31
32	White Medical Cabinet	2005	3,037		20	253	253	253	32
33	Door Entry System	2005	765		20	70	70	70	33
34	TOTAL (lines 1 thru 33)		$ 596,508	$ 79,642		$ 45,286	$ (34,356)	$ 155,187	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 596,508	$ 79,642		$ 45,286	$ (34,356)	$ 155,187	1
2	Monitoring System/ Video Processor	2005	1,298		20	108	108	108	2
3	Interior Design Service	2005	2,665		20	111	111	111	3
4	Walk-In Freezer	2005	1,299		20	31	31	31	4
5	Wall Mural	2005	2,800		20	23	23	23	5
6	Computer Software	2005	951		20	53	53	53	6
7	Conference Room And Lobby Entrance Improvements	2005	1,250		20	10	10	10	7
8	Improvements To Patients Rooms	2005	1,530		20	26	26	26	8
9	Pegasus Furniture	2005	5,280		20	44	44	44	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 613,581	$ 79,642		$ 45,692	$ (33,950)	$ 155,593	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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53									53
54									54
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Allocated from 7257 N. Lincoln Avenue, LLC		2004	2004	$ 47,536	$ 1,219	35	$ 1,358	$ 139	$ 2,886	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocated from Nucare Services Corp.			2003	794	40	20	40		84	9
10	Allocated from Nucare Services Corp.			2004	16,126	806	20	806		1,378	10
11	Allocated from Nucare Services Corp.			2005	956	267	20	24	(243)	24	11
12											12
13	Allocated from 7257 N. Lincoln Avenue, LLC			2005	4,333	302	20	108	(194)	108	13
14	Allocated from 7257 N. Lincoln Avenue, LLC			2004	945	535	20	47	(488)	71	14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 70,690	$ 3,169		$ 2,383	$ (786)	$ 4,551	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 695,366	$ 39,365	$ 72,091	$ 32,726	10	$ 466,189	71
72	Current Year Purchases	167,806	10,357	10,357		10	10,357	72
73	Fully Depreciated Assets	14,192				10	14,192	73
74								74
75	TOTALS	$ 877,364	$ 49,722	$ 82,448	$ 32,726		$ 490,738	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	98 CHEVY VAN	2001	$ 11,532	$ 2,306	$ 1,153	$ (1,153)	5	$ 5,093	76
77										77
78										78
79										79
80	TOTALS			$ 11,532	$ 2,306	$ 1,153	$ (1,153)		$ 5,093	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,507,759	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 131,670	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 129,293	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,377)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 651,424	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Hillside Limitd Partnership
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ 1,166,145			3
4	Additions							4
5	Allocated from Nucare				370			5
6								6
7	TOTAL				$ 1,166,515 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO
16. Rental Amount for movable equipment: $ 9,430 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Nucare		$	$ 1,883	17
18					18
19					19
20					20
21	TOTAL		$	$ 1,883	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 264,820	$		$ 264,820	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			181,168			181,168	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			259,752			259,752	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				348,672		348,672	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental			2,786		7,140	109,879		119,805	13
14	TOTAL			$ 2,786		$ 712,880	$ 458,551		$ 1,174,217	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Renaissance at Hillside # 0042176 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	5,124		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,320,687		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	100,990		6
7	Other Prepaid Expenses	148,119		7
8	Accounts Receivable (owners or related parties)	1,237,977		8
9	Other(specify): See Attached Schedule	220,023		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,032,920	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	851,223		15
16	Equipment, at Historical Cost	848,307		16
17	Accumulated Depreciation (book methods)	(1,036,987)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	37,608		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(27,579)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule	8,540		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 681,112	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,714,032	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 987,451	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	(2,833)		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	284,748		30
31	Accrued Taxes Payable (excluding real estate taxes)	22,047		31
32	Accrued Real Estate Taxes(Sch.IX-B)	423,191		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	315,251		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,029,855	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	3,949,576		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,949,576	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,979,431	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,265,399)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,714,032	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Renaissance at Hillside # 0042176 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,799,120)	1	
2	Restatements (describe):		2	
3	See Attached	3,691	3	
4	Rounding	2	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,795,427)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(469,972)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (469,972)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,265,399)	24	*

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,561,394	1
2	Discounts and Allowances for all Levels	(957,788)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,603,606	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,792,614	6
7	Oxygen	1,196	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,793,810	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	697,472	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	46,543	19
20	Radiology and X-Ray	17,338	20
21	Other Medical Services	58,081	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 819,434	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	944	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 944	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	58,377	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 58,377	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,276,171	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,332,434	31
32	Health Care	3,447,071	32
33	General Administration	2,460,788	33
	B. Capital Expense		
34	Ownership	2,103,168	34
	C. Ancillary Expense		
35	Special Cost Centers	1,310,702	35
36	Provider Participation Fee	91,980	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 10,746,143	40
41	**Income before Income Taxes (line 30 minus line 40)****	(469,972)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (469,972)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Cash Basis **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,951	2,152	$ 99,401	$ 46.19	1
2	Assistant Director of Nursing	2,188	2,591	88,350	34.10	2
3	Registered Nurses	13,962	15,127	410,298	27.12	3
4	Licensed Practical Nurses	35,063	37,691	956,534	25.38	4
5	CNAs & Orderlies	85,362	92,170	879,139	9.54	5
6	CNA Trainees					6
7	Licensed Therapist	120	120	2,786	23.22	7
8	Rehab/Therapy Aides	12,476	13,344	205,321	15.39	8
9	Activity Director	2,759	3,096	52,444	16.94	9
10	Activity Assistants	8,603	9,306	76,367	8.21	10
11	Social Service Workers	7,661	8,365	135,744	16.23	11
12	Dietician	2,003	2,153	43,635	20.27	12
13	Food Service Supervisor					13
14	Head Cook	6,322	7,266	79,640	10.96	14
15	Cook Helpers/Assistants	20,043	21,278	173,790	8.17	15
16	Dishwashers					16
17	Maintenance Workers	2,808	3,130	42,303	13.52	17
18	Housekeepers	25,247	27,420	261,612	9.54	18
19	Laundry					19
20	Administrator	1,701	1,790	79,384	44.35	20
21	Assistant Administrator					21
22	Other Administrative	2,944	2,985	92,557	31.01	22
23	Office Manager					23
24	Clerical	6,709	7,526	198,407	26.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,815	1,968	34,010	17.28	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	3,610	3,668	132,409	36.10	33
34	TOTAL (lines 1 - 33)	243,347	263,146	$ 4,044,131 *	$ 15.37	34

SEE ACCOUNTANTS' COMPILATION REPORT

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	564	$ 20,398	01-03	35
36	Medical Director	Monthly	20,900	09-03	36
37	Medical Records Consultant	Monthly	4,224	10-03	37
38	Nurse Consultant	361	9,031	10-03	38
39	Pharmacist Consultant	Monthly	3,292	10-03	39
40	Physical Therapy Consultant	14	674	10a-03	40
41	Occupational Therapy Consultant	3	133	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	14	649	10a-03	43
44	Activity Consultant	48	2,551	11-03	44
45	Social Service Consultant	62	3,336	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,066	$ 65,188		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	8	$ 420	10-03	50
51	Licensed Practical Nurses	7,816	253,738	10-03	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	7,824	$ 254,158		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Aaron Topper	Administrator	0	$ 7,545
Greg Seeger	Administrator	0	41,062
John Stare	Administrator	0	30,057
Barbara Brauen	Administrator	0	720
David Schechter	Exec. Admin.	0	30,762
Kathleen Brander	Dir Regulatory Mgmt	0	9,707
See Supplemetal Schedule			52,088
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 171,941

B. Administrative - Other

Description	Amount
Carepath Network Fees	$ 17,600
Management Fees - Nucare Services Corp	381,843
Management Fees - JLR Management	120,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 519,443

C. Professional Services

Vendor/Payee	Type	Amount
HDSI	Computer	$ 12,207
CDW	Computer	4,185
Giftrap	Computer	5,222
PDS Solutions	Computer	8,774
Transworld Systems	Computer	540
Medifax	Computer	763
Frost Ruttenberg & Rothblatt	Accounting	14,172
Personal Planners	Unemployment Tax Cons	2,505
Purchasing Plus	Purchasing Services	50
See Attached	Legal	45,029
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 93,447

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 60,509
Unemployment Compensation Insurance	104,271
FICA Taxes	304,761
Employee Health Insurance	162,916
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Union Pension Benefits	30,903
Other Employee Benefits	19,398
401K matching expense	5,893
TOTAL (agree to Schedule V, line 22, col.8)	$ 688,651

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,529
Advertising: Employee Recruitment	38,989
Health Care Worker Background Check	4,060
(Indicate # of checks performed 406)	
Yellow Page	211
Advertising And Promotional	28,616
Licenses & Inspections	2,069
Dues & Subscriptions	10,050
Allocated from Carepath	190
Allocated from Nucare	1,382
Less: Public Relations Expense	( )
Non-allowable advertising	(28,616)
Yellow page advertising	(211)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 59,269

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	7,546
Allocated from Carepath	128
Allocated from Nucare	470
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,144

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Renaissance at Hillside # 0042176 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Renaissance at Hillside # 0042176 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IL Council on LTC $8,447**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **49,520** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **91,980**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.